

# C+D

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How stable are your stock levels? Tell us in the C+D Stock Survey

See page 23



### PLUS

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You have told us that a successful professional leadership body is important to you. By voting 'yes' to the Charter changes, you can help build an influential professional leadership body that will speak with a strong voice to build a better profession.

#### **How to vote**

You can vote by post, by phone, online or by text message. Voting closes at noon on 20 July 2009.

#### **Vote YES today**

To find out how you can help shape the new professional leadership body and ensure new products and services meet your needs visit [www.pharmacyplb.com](http://www.pharmacyplb.com) or call 0808 168 5141.



**"As a new generation pharmacist I want to be confident in what the future holds in store for the profession and its members, hence I will be voting 'yes' to the Charter changes."**

**Ravi Patel,  
Locum Pharmacist.**

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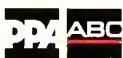
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**TABPI Awards 2008**

Winner for news coverage



## ‘BLOWOUTS ON DESIGNER CLOTHES OR LUXURY HOLIDAYS MUST BE TWO A PENNY ... BUT A £3,000 SPENDING SPREE ON ZYPREXA IS SURELY UNIQUE’

You can imagine some baffled expressions when bankers went to process Robert Curd's credit card payments this month (see p5). Blowouts on designer clothes or luxury holidays must be two a penny at the HQ of MasterCard or Visa, but a £3,000 spending spree on Zyprexa is surely unique. Yet, that's the sum Mr Curd has had to spend on his card to get Lilly products to his pharmacies under the company's new distribution deal.

Some quarters might see the pharmacist as an innocent victim of another manufacturer tinkering with the NHS supply chain. But there are two sides to every story. A black mark showed up when Lilly ran an independent credit check on Mr Curd's business. As a savvy commercial operator you can hardly then blame Lilly for being reluctant to offer extensive loan terms.

At this point though, you would expect a frank exchange between pharmacist and manufacturer over the terms of the new account. But it appears that this heart-to-heart is still waiting to happen. Instead, Mr Curd has liaised through Phoenix – one of the wholesalers chosen by Lilly to distribute products under its supply deal.

His decision was entirely natural. Pharmacists are used to dealing with

their wholesaler when they have a supply issue. Working together, the two parties have forged a strong working relationship over many years. Manufacturers and their supply deals are the new kids on the block and, as such, are eyed with suspicion. That's not to say they can't work – in many cases they already do – but what's absolutely essential is clear communication between both sides.

Without this dialogue it's not surprising there are teething troubles cropping up with distribution changes. Lilly says that if Mr Curd picks up the phone to them they can look to sort out his ordering difficulties. It shows that it's going to be down to pharmacists to give feedback when they're not getting the service they need. There is no room for the sector to be a shrinking violet or manufacturers will be blissfully unaware when there's anything wrong.

That's why C+D has this week launched a survey to gauge the stock issues affecting pharmacies. We hope that contractors can spare the time to complete the 10-step Stock Survey (see p23). We want to get a clear idea of how recent supply shortages have affected your business and the patients you serve.

**Max Gosney, News Editor**

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Is it worth becoming a pharmacist prescriber?

# Wholesalers: we need national plan for swine flu antiviral supply

BAPW urges centrally driven response to distribution as PCTs develop independent strategies

**Tom Hawkins  
and Chris Chapman**

The UK's major pharmaceutical wholesalers are calling for a national supply strategy for swine flu antivirals after being left out of distribution plans being drawn up by PCTs.

Fewer than a third of the 152 PCTs across England have discussed the delivery of drugs such as Tamiflu

with members of the British Association of Pharmaceutical Wholesalers (BAPW), the organisation said.

Of those that have made contact, the BAPW said that none had reached a supply agreement with a wholesale partner.

Executive director Martin Sawyer told C+D he expected a more centrally driven response to drug

supply in the context of a swine flu pandemic.

"Our primary concern is that in the midst of local epidemic outbreaks our member companies will be flooded with last minute requests for help from PCTs," he said, adding: "It could be difficult for those members to assist."

Mr Sawyer said the BAPW was "seriously considering" writing to health ministers to call for a national solution.

Health secretary Andy Burnham declared a move from containment to the treatment of swine flu on July 2, handing responsibility for antivirals from the Health Protection Agency to primary care organisations.

A spokesperson for the

Department of Health said local health trusts, overseen by Strategic Health Authorities, were responsible for establishing collection points – which include pharmacies – and managing the supply of antivirals from the national stockpile.

"Many local health trusts have already successfully mobilised their antiviral collection points," they said.

Steve Barnett, chief executive of NHS Confederation, which represents PCTs, said of the move to the treatment phase: "NHS managers do not underestimate the task ahead and hospitals, PCTs and ambulance services will all need to use the next few weeks to ensure they are prepared for a major flu outbreak."

## Infection concern as swine flu cases rise

Pharmacists on the front line of the swine flu pandemic have told C+D of their concern at being infected as the number of cases across the UK continues to rise.

Since the move to a treatment phase on July 2, many pharmacies are now operating as distribution points for the antiviral Tamiflu.

London pharmacist Raj Radia works at Spring Pharmacy, one of five collection points in Hackney. He said there had been a significant rise in infected patients coming in for Tamiflu.

"People with swine flu are still walking about all over the place," he said. "I advise them to go back home and stay there."

Sulman Durrani, a locum from Bedfordshire, said there was a lack of advice for pharmacists.

"We're pretty much on the front line. I'm not sure what's going on with regard to protection," he said.

Lisa Kellett, whose Barrowcliff Pharmacy in Scarborough issued 80 Tamiflu packs in five days, said she did not feel at increased risk.

She said: "Everybody's got the concern, but we're as likely to get it stood in a queue at the supermarket than from anybody coming in."

Ms Kellett said the pharmacy was being wiped with disinfectant and staff used hand gel after handling each Tamiflu prescription.

The Department of Health is in consultation with pharmacy bodies to develop guidance to support pharmacists dealing with pandemic flu. A spokesperson said it would be released "in the very near future".

Health workers have been identified by the World Health Organization as a priority group for vaccination, expected by autumn.

### Dunstable GP tributes

A community pharmacist close to the first health professional to die after contracting swine flu has paid tribute to a colleague who "dedicated his life to his patients".

Dr Michael Day died on July 11 from natural causes, despite early indications that his death was linked to the virus.

Dunstable pharmacist Balbir Parkash, who had known Dr Day for 20 years, described his death as a "bolt from the blue". Mr Parkash said Dr Day had regularly visited his pharmacies and had helped counter assistant Jamie Parmenter, 19, apply to study medicine.



Fewer than a third of PCTs have discussed delivery of antivirals such as Tamiflu with BAPW members

### Swine flu facts

- GP presentations for flu-like illness are 66 per cent above seasonal average
- Most common in children aged 5-14 years
- Majority of cases are mild
- 335 hospitalisations in England, 40 in Scotland, seven in Wales
- 12 deaths confirmed with swine flu in England, two in Scotland.

# Contractor puts NHS drugs on credit card

Lilly imposes £500 monthly order limit following credit check

Max Gosney  
mgosney@cmpmedica.com

A pharmacist has spent £3,000 on a personal credit card to order medicines after his business was refused credit by Eli Lilly and Company Limited.

Robert Curd took drastic action when Lilly imposed a £500 per month order limit – well below his £1,500 average outlay – under its new distribution deal launched this month.

Lilly said the limit was determined after routine checks through independent credit rating agencies.

The Isleworth pharmacist has had to open an account with Phoenix under the distribution deal as he can no longer get Lilly medicines from his main wholesaler, Alliance Healthcare.

Mr Curd, of AC Curd Ltd, admitted that his poor credit score with Lilly could be the result of his late return of accounts to Companies House.

However, he added: "I don't think you'll find any other of my suppliers have difficulty giving me credit."

Mr Curd said he had been surprised and frustrated by the spending limit. "When you use Zyprexa at £100 a box that £500 limit is not going to get you very far. I took out the credit card because I've got patients who need the drugs," he said.

Lilly responded that, like other



**Credit control:** Mr Curd was "surprised and frustrated" that his spending on Lilly products was limited to £500 a month

businesses, it based trading decisions on data provided by credit agencies.

The firm urged Mr Curd to make direct contact so the issue could be resolved. Lilly offered several options for pharmacists with bad credit scores who needed medicines, the firm stressed.

A Lilly spokesperson told C+D: "We have put credit card systems in place so pharmacists can order. There have also been situations

where product has been supplied in good faith. There's flexibility in the system."

Lilly said a "handful" of pharmacists had contested credit ratings since its distribution deal went live on July 6. The deal means Lilly medicines are only supplied via Phoenix and AAH.

**Complete the C+D Stock Survey and you could win an iPod Shuffle**  
Turn to p23

## Talks with prosecutors begin over single dispensing errors

The MHRA has approached the Crown Prosecution Service to stop pharmacists being charged for single dispensing errors.

Speaking exclusively to C+D, MHRA head of enforcement Mick Deats said the CPS had been approached, but detailed discussions were yet to take place. The CPS and MHRA would look for "consistency" in prosecutions, he said.

In a statement, the MHRA said the talks would look to deliver "interim solutions until changes to the Medicines Act are considered later this year".

Last month England's chief pharmacist Keith Ridge revealed the MHRA had been tasked to approach the CPS (C+D, June 20, p7). **CC**

## RP

Responsible Pharmacist  
absence planning – p14

www.responsiblepharmacist.com

## PNAs 'huge burden'

Guidance to help PCTs produce pharmaceutical needs assessments (PNAs) has highlighted the "huge burden" the documents will be, a legal expert has said. Law firm Charles Russell made the warning as NHS Employers launched a "practical guide" to help PCTs get to grips with PNAs.

[www.chemistanddruggist.co.uk](http://www.chemistanddruggist.co.uk)

## TV show seeks pharmacy

BBC2 show Mary Queen of Shops is on the hunt for a community pharmacy in need of a makeover to star in an upcoming episode.

If you're an independent pharmacy eager to take part, email C+D at [haveyoursay@cmpmedica.com](mailto:haveyoursay@cmpmedica.com)

## PDA launches RP survey

A campaign by the Pharmacists' Defence Association (PDA) to delay the responsible pharmacist (RP) regulations has gathered pace, with the launch of a survey to highlight opposition. Over 1,000 responses so far showed problems "with a capital P" over RP rules, which come into force on October 1, the PDA said.

[www.chemistanddruggist.co.uk](http://www.chemistanddruggist.co.uk)

## Unlicensed prescribing

Pharmacist independent prescribers are now able to prescribe unlicensed medicines on the same basis as doctors. For more information on becoming a prescriber, see Jobs on p25.

## Schering Award winner

Hazel Somerville has been confirmed as the 24th winner of the College of Pharmacy Practice's Schering Award. Mrs Somerville, who is now retired, was head pharmacist at the Commission for Social Care Inspection. She received the award from CPP chairman David Morgan at a dinner in London on July 1.

## NHS plan 'did not deliver'

A 10-year blueprint for NHS services has not delivered, MPs have ruled. The NHS plan of 2000 had led to improved access to medicines, but patients were still not empowered to look after their health as the document aimed, the all-party group on primary care and drug misuse said.

## The answer is...

To celebrate C+D's 150th birthday this September, we look back at the events of 1859

### The Pig War



Britain and America almost go to war after a shooting incident involving a wandering pig

# 1859

## In Brief

**Clarification**

C+D would like to clarify that the introduction of a pharmacy QOF is just one of a number of proposals the Conservatives are considering, and not a confirmed policy as suggested by C+D (July 4, p5).

**South Asian obesity**

An Asian health campaign group has argued that the criteria for obesity in South Asian people should be changed. The South Asian Health Foundation said a threshold BMI of 23 and a waist measurement of over 90cm for men and over 80cm for women should be considered overweight. [www.sahf.org.uk](http://www.sahf.org.uk)

**Nice thinks twice**

Nice is to reconsider the evidence for lapatinib and capecitabine combined treatment in advanced breast cancer, following a successful appeal by GSK. The move follows a change in Nice criteria for decisions on treatments used near the end of life.

**Arthritis undetected**

Many rheumatoid arthritis sufferers are not being diagnosed and treated quickly enough, according to a National Audit Office report, which found patients pay four visits to their GP on average before getting a diagnosis. [www.nao.org.uk](http://www.nao.org.uk)

**Lambeth HQ to be shared**

The General Pharmaceutical Council (GPhC) will be based at the RPSGB's Lambeth HQ when it takes over as pharmacy regulator next spring.

The announcement came at the latest meeting of PROLOG, the group charged with delivering the new regulator. Member Chris Martin told C+D: "It gives an opportunity to share resources and I think it's a sensible way forward for now."

The GPhC has been set up to take over regulation of pharmacists from the RPSGB in a government bid to bring greater impartiality to the role. It would be "vitally important" to keep the two organisations physically separate during co-location to achieve this aim, the RPSGB said. **MG**

# Scots told to make own minds up on charter vote

But CPS maintains stance against RPSGB-led body

**Jennifer Richardson**  
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Community Pharmacy Scotland (CPS) has called on Scottish pharmacists to vote on proposed changes to the RPSGB's charter, while maintaining its opposition to the Society forming the new professional body.

Members should voice individual opinions on the professional body by responding to the charter ballot which closes on Monday (July 20), Community Pharmacy Scotland (CPS) said.

The call follows the Scottish contract negotiator's strongly worded response against proposed charter changes in a Society consultation which closed in May.

In it, CPS slammed the Society's drive to form the basis of the new professional body. "[The Society] has not offered members the opportunity to comment on the possible alternatives," CPS said. "There has to be a fresh start and other options must be explored. If it is too late to ensure that the Society's assets are transferred to a new body or bodies then so be it."

CPS had "no confidence" that the Society's proposed structure for the new body would deliver for Scotland. "There appears to be no overall vision for pharmacy," it added.

Despite this, said CPS head of policy and development Elspeth Weir, "we do feel it's for the individual to decide whether the professional body is for them".

RPSGB director for Scotland Lyndon Braddick said he was not surprised by CPS's comments. He added that the negotiator was "out of step" with other organisations representing Scottish pharmacists in its desire for a separate professional body for Scotland. Mr Braddick hoped CPS and the professional body's Scottish assembly would continue to present a united front to policy makers, he added.

## Electronic prescription transfer goes live

Scotland's electronic prescription transfer service is now fully rolled out and live, the Scottish Government has announced.

After viewing a demonstration of the electronic Acute Medication Service (eAMS) at Glasgow's LG Pharmacy this week, health secretary Nicola Sturgeon said: "This shows the demand among GPs and pharmacists to work together to make the best use of the latest technology to improve services."

Contractor Graeme MacBride of West Calder's MacBride Pharmacy said the rollout was a "positive step forward" and a boost for patient safety, but that prescription scanning was slower than anticipated. Community Pharmacy Scotland (CPS) spokesperson Alex MacKinnon agreed this was "a valid point", but that the contract negotiator was "very pleased" with the service. **JR**

Vote on the charter changes

[www.chemistanddruggist.co.uk/news](http://www.chemistanddruggist.co.uk/news)

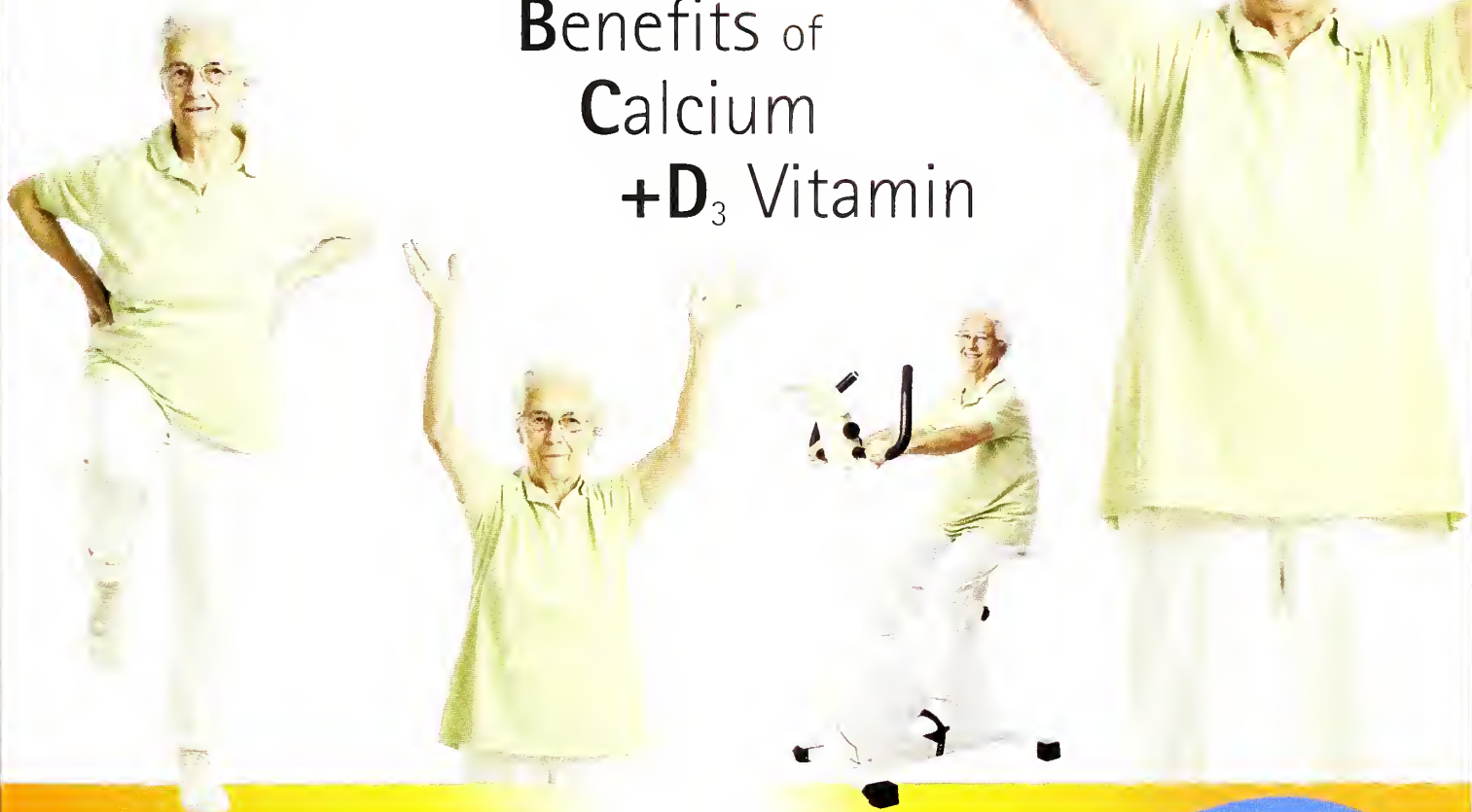


Olympic glory: a PCT, including a pharmacy, will emerge at the site of the 2012 Olympics after the games have ended, officials have announced. Speaking to C+D, the Olympic Development Authority (ODA), the body overseeing delivery of the London games, said the move was part of a legal requirement for the games, but showed the project's "firm commitment to building a legacy". The ODA is negotiating with Newham PCT, currently responsible for healthcare at the Stratford site, and is "still in the early stages of planning", the spokesman added.

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Adverse events should be reported. Reporting forms and information can be found at [www.yellowcard.gov.uk](http://www.yellowcard.gov.uk). Adverse events should also be reported to Novartis Consumer Health on 01403 323046 or [medicalaffairs.uk@novartis.com](mailto:medicalaffairs.uk@novartis.com).

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## Dispensary talk

Who will triumph in the Ashes this summer?



"On the form of the Welsh game, I'd say Australia. But my heart is with England."

**Kevin Western, Day Lewis, Coggeshall, Essex**



"England of course! There's no doubt in my mind."

**Raj Radia, Spring Pharmacy, Hackney, London**

## Web verdict

England 63%

Australia 37%

**Armchair view:** Monty Panesar and Jimmy Anderson's first test heroics seem to have inspired confidence in a ropey-looking England side, with six out of 10 respondents backing Andrew Strauss's team to win back the Ashes.

**Next week's question:**

Has swine flu caused a rise in your OTC medicine sales?

[www.chemistanddruggist.co.uk](http://www.chemistanddruggist.co.uk)

# Prescription errors rife, Avicenna survey finds

But NHS defends payments as 99.8 per cent accurate

**Jennifer Richardson**  
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Continuing incorrect prescription payments to pharmacies cast "serious doubts" on NHS paymasters' accuracy, a buying group has said.

Feedback on payments by NHS Prescription Services (NHS PS, formerly Prescription Pricing Division) from Avicenna members unveiled underpayments of up to £2,300 in a single month.

NHS PS insisted it "consistently" paid contractors to 99.8 per cent accuracy, as agreed with the Department of Health. But in a statement Avicenna said: "Judging from our feedback, their accuracy falls significantly outside these parameters."

One member was underpaid £5,720 over eight months when items were omitted from every payment during this period – up to 168 items in a monthly batch. Another had 14 consecutive batches rechecked, revealing errors in every payment and a net underpayment of £7,270.

## Avicenna's survey by numbers

611

items omitted from one member's payments over eight months – totalling £5,710

14

consecutive monthly prescription payments contained errors for one member

£2,300

maximum underpayment on prescriptions in a single month

Source: survey of NHS reimbursement from 30 Avicenna members

In yet another recheck, NHS PS reported a £174 underpayment, but a further check by PSNC revealed an additional shortfall of £422. On this latter case, NHS PS told C+D: "We are confident that checks are carried out to a high degree of accuracy."

Avicenna was concerned that the "limited information" given to contractors made payments "impossible to reconcile". NHS PS said it was "looking at the feasibility of providing more information to contractors".

Avicenna recently met NHS PS to discuss its findings but had decided

to make them public because the buying group was "not satisfied" with the response it got, Mr Jetha told C+D. "I'm not interested in how they do it," he said. "We want to be accurately paid – how they do it is up to them."

PSNC had identified "some improvement" in NHS PS's automated prescription pricing system (CIP), said head of information services Lindsay McClure. But there remained "unresolved issues leading to errors", which PSNC was "closely monitoring".



Nine North London pharmacies have launched NHS Health Checks across Camden to screen for CVD this month. The checks, which aim to spot vascular diseases in 40 to 74-year-olds, were kicked off by Camden mayor Omar Ansari (pictured left). The mayor popped in to Greenlight Pharmacy in Euston for his assessment with pharmacist Alistair Murray (right). Delivering the checks through pharmacies meant maximum convenience for patients, said Camden PCT's primary care contracts manager Tim Shaw. He said: "[Pharmacists] are easier to access than a GP and you don't need to make an appointment to receive your pharmacy health check." UK-wide vascular checks for 40 to 74-year-olds were launched this April.

## New minister quick to praise

Pharmacy minister Mike O'Brien said his first weeks in the post had taught him the "enormous reliance" communities place on their local pharmacies.

The comments came in Mr O'Brien's first speech to the profession at a Westminster reception last week.

"Good progress" had been made on the white paper, he told the all-party pharmacy group's summer reception.

But he acknowledged that "there's a lot of work to be done". Mr O'Brien was particularly keen for pharmacists to treat minor ailments and provide Health Checks.

He said: "I want quality, prevention and safety to be at the centre of pharmacy services." JR

# IMPORTANT SAFETY INFORMATION

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**Inadvertent, unintentional or unsupervised switching of immediate- or prolonged-release formulations of tacrolimus is unsafe.<sup>1</sup>**

**This can lead to graft rejection or increased incidence of side effects, including under- or over immunosuppression, due to clinically relevant differences in systemic exposure to tacrolimus.<sup>1,2</sup>**

Patients should be maintained on a single formulation of tacrolimus with the corresponding daily dosing regimen; alterations in formulation or regimen should only take place under the close supervision of a transplant specialist.<sup>1,2</sup>

Following conversion to any alternative formulation, therapeutic drug monitoring must be performed and dose adjustments made to ensure that systemic exposure to tacrolimus is maintained.<sup>1,2</sup>

**References:** 1. ADVAGRAF Summary of Product Characteristics. 2. Drug Safety Update MHRA January 2009, Volume 2, Issue 6.

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[www.mhra.gov.uk/Publications/Safetyguidance/DrugSafetyUpdate/CON035989](http://www.mhra.gov.uk/Publications/Safetyguidance/DrugSafetyUpdate/CON035989)

[www.emc.medicines.org.uk/medicine/19814/SPC/Advagraf](http://www.emc.medicines.org.uk/medicine/19814/SPC/Advagraf)

**Presentations:** ADVAGRAF<sup>®</sup> Prolonged-release hard capsules containing tacrolimus 0.5 mg, 1 mg and 5 mg. PROGRAF<sup>®</sup> hard capsules containing tacrolimus 0.5 mg, 1 mg and 5 mg.

**Indications:** ADVAGRAF<sup>®</sup> and PROGRAF<sup>®</sup> Prophylaxis of transplant rejection in adult liver or kidney allograft recipients and treatment of allograft rejection resistant to treatment with other immunosuppressive medicinal products. **Posology and Administration:** ADVAGRAF<sup>®</sup> and PROGRAF<sup>®</sup> therapy require careful monitoring by adequately qualified and equipped personnel. Either drug should only be prescribed, and changes in immunosuppressive therapy initiated, by physicians experienced in immunosuppressive therapy and the management of transplant patients. Dosage recommendations given below should be used as a guideline. ADVAGRAF<sup>®</sup> or PROGRAF<sup>®</sup> are routinely administered in conjunction with other immunosuppressive agents in the initial post-operative period. The dose may vary depending on the immunosuppressive regimen chosen. Dosing should be based on clinical assessments of rejection and tolerability aided by blood level monitoring. To suppress graft rejection immunosuppression must be maintained so no limit to the duration of oral therapy can be given. The daily dose of ADVAGRAF<sup>®</sup> capsules should be taken once daily in the morning with water at least 1 hour before or 2-3 hours after a meal. PROGRAF<sup>®</sup> Capsules should be taken for ADVAGRAF<sup>®</sup> in two divided doses. ADVAGRAF<sup>®</sup>: In stable patients converted from PROGRAF<sup>®</sup> (twice daily) to ADVAGRAF<sup>®</sup> (once daily) on a 1:1 (mg/mg) total daily dose basis the systemic exposure to tacrolimus for ADVAGRAF<sup>®</sup> was approximately 10% lower than for PROGRAF<sup>®</sup>. The relationship between tacrolimus trough levels (C<sub>0</sub>) and systemic exposure (AUC<sub>0-24</sub>) for ADVAGRAF<sup>®</sup> is similar to that of PROGRAF<sup>®</sup>. When converting from PROGRAF<sup>®</sup> capsules to ADVAGRAF<sup>®</sup> trough levels should be measured before and within two weeks after conversion. In *de novo* kidney and liver transplant patients AUC<sub>0-24</sub> of tacrolimus for ADVAGRAF<sup>®</sup> on Day 1 was 30% and 50% lower respectively, when compared with that for PROGRAF<sup>®</sup> at equivalent doses. 8y Day 4, systemic exposure as measured by trough levels is similar for both kidney and liver transplant patients with both formulations. **Race:** In comparison to Caucasians, Afro-Caribbean patients may require higher tacrolimus doses to achieve similar trough levels. **Prophylaxis of transplant rejection – liver and kidney:** Initial dose of ADVAGRAF<sup>®</sup> and PROGRAF<sup>®</sup> Capsules is 0.10-0.20 mg/kg/day for liver transplantation and 0.20-0.30 mg/kg/day for kidney transplantation starting approximately 12-18 hours for ADVAGRAF<sup>®</sup> and 2hrs for PROGRAF<sup>®</sup> after completion of liver or within 24 hours of completion of kidney transplant surgery. **Dose adjustment post-transplant:** ADVAGRAF<sup>®</sup> and PROGRAF<sup>®</sup> doses are usually reduced in the post-transplant period. It is possible in some cases to withdraw concomitant immunosuppressive therapy leading to ADVAGRAF<sup>®</sup> monotherapy or PROGRAF<sup>®</sup> dual therapy or monotherapy. Post-transplant improvement in the condition of the patient may alter the pharmacokinetics of tacrolimus and may necessitate further dose adjustments. **Dose recommendations – Conversion to ADVAGRAF<sup>®</sup>:** Patients maintained on twice daily PROGRAF<sup>®</sup> requiring conversion to once daily ADVAGRAF<sup>®</sup> should be converted on a 1:1 (mg/mg) total daily dose basis. Following conversion, tacrolimus trough levels should be monitored and if necessary dose adjustments made. Care should be taken when converting patients from ciclosporin-based to tacrolimus-based therapy. Initiate ADVAGRAF<sup>®</sup> after considering ciclosporin blood concentrations and clinical condition of patient. Delay dosing in presence of elevated ciclosporin blood levels. Monitor ciclosporin blood levels following conversion. **Dose recommendations – Rejection therapy:** For conversion of kidney and liver recipients from other immunosuppressants to once daily ADVAGRAF<sup>®</sup>, begin with the respective initial dose recommended for rejection prophylaxis. In adult heart transplant recipients converted to ADVAGRAF<sup>®</sup>, an initial oral dose of 0.15 mg/kg/day should be administered once daily in the morning. For other allografts, see SPC. **Dose adjustments in specific populations:** See SPC. **Target whole blood trough concentration recommendations:** Blood trough levels for ADVAGRAF<sup>®</sup> should be drawn approximately 24 hours post-dosing, just prior to the next dose, for PROGRAF<sup>®</sup> approximately 12 hours post-dosing. Frequent trough level monitoring in the first two weeks post-transplant is recommended, with periodic monitoring during maintenance therapy. Monitoring is also recommended following conversion from PROGRAF<sup>®</sup> to ADVAGRAF<sup>®</sup>, dose adjustment, changes in the immunosuppressive regimen, or co-administration of substances which may alter tacrolimus whole blood concentrations (see 'Warnings and Precautions' and 'Interactions'). Adjustments to the ADVAGRAF<sup>®</sup> and PROGRAF<sup>®</sup> dose regimen may take several days before steady state is achieved. Most patients can be managed successfully if tacrolimus blood concentrations are maintained below 20 ng/mL. In clinical practice, whole blood trough levels have been 5-20 ng/mL in liver transplant recipients and 10-20 ng/mL in kidney transplant recipients early post-transplant, and 5-15 ng/mL during maintenance therapy. **Contraindications:** Hypersensitivity to tacrolimus or other macrolides or any excipient. **Warnings and Precautions:** Medication errors, including inadvertent, unintentional or unsupervised substitution of immediate- or prolonged-release tacrolimus formulations, have been observed. This has led to serious adverse events, including graft rejection, or other side effects which could be a consequence of either under- or over-exposure to tacrolimus. Patients should be maintained on a single formulation of tacrolimus with the corresponding daily dosing regimen; alterations in formulation or regimen should only take place under the close supervision of a transplant specialist. ADVAGRAF<sup>®</sup> only limited experience in non-Caucasian patients and those at elevated immunological risk. ADVAGRAF<sup>®</sup> and PROGRAF<sup>®</sup>: During initial period routinely monitor blood pressure, ECG, neurological and visual status, fasting blood glucose, electrolytes (particularly potassium), liver and renal function tests, haematology parameters, coagulation values, and plasma protein determinations, consider adjusting the immunosuppressive regimen if clinically relevant changes are seen. Herbal preparations, including those containing St. John's Wort, should be avoided. Extra monitoring of tacrolimus concentrations is recommended during episodes of diarrhoea. Avoid concomitant administration of ciclosporin. Ventricular hypertrophy or hypertrophy of the septum (reported as

cardiomyopathy) have been seen rarely, other risk factors for these conditions include pre-existing heart disease, corticosteroid usage, hypertension, renal or hepatic dysfunction, infections, fluid overload, and oedema. Patients are at increased risk of all opportunistic infections including BK Virus associated nephropathy and JC Virus associated progressive multifocal leukoencephalopathy. Physicians should consider this in their differential diagnosis in immunosuppressed patients with deteriorating renal function or neurological symptoms. Patients have been reported to develop posterior reversible encephalopathy syndrome (PRES). If so radiological tests should be performed. If PRES is diagnosed, adequate blood pressure and seizure control and immediate discontinuation of tacrolimus is advised. Echocardiography or ECG monitoring pre-and post-transplant is advised in high-risk patients, and dose reduction of and/or a change of immunosuppressive agent should be considered if abnormalities develop. Tacrolimus may prolong the QT interval. Exercise caution in patients with diagnosed or suspected Congenital Long QT Syndrome. EBV-associated lymphoproliferative disorders have been reported. Concomitant use of other immunosuppressives such as antilymphocytic antibodies increases the risk of EBV-associated lymphoproliferative disorders. EBV-VCA negative patients have been reported to have increased risk of lymphoproliferative disorders. EBV-VCA serology should be ascertained before starting tacrolimus treatment. During treatment, careful monitoring with EBV-PCR is recommended. Exposure to sunlight and UV light should be limited. The risk of secondary cancer is unknown. Capsules contain lactose. **Interactions:** See SPC. **Pregnancy and lactation:** Tacrolimus can be considered in pregnant women when there is no safer alternative. See SPC. **Undesirable effects:** Medication errors have been observed. A number of associated cases of transplant rejection have been reported (frequency cannot be estimated from the available data). Many of the following adverse drug reactions are reversible and/or respond to dose reduction. **Very Common (>1/10):** Hyperglycaemic conditions, diabetes mellitus, hyperkalaemia, insomnia, tremor, headache, hypertension, diarrhoea, nausea, renal impairment. **Common (>1/100 to <1/10):** haematological abnormalities, hypomagnesaemia, hypophosphataemia, hypokalaemia, hypocalcaemia, hyponatraemia, fluid overload, hyperuricaemia, appetite decreased, anorexia, metabolic acidosis, hyperlipidaemia, hypercholesterolaemia, hypertriglyceridaemia, anxiety symptoms, confusion and disorientation, depression, mood disorders and disturbances, nightmare, hallucination, seizures, disturbances in consciousness, paraesthesia and dysesthesias, peripheral neuropathies, dizziness, writing impaired, vision blurred, photophobia, eye disorders, tinnitus, ischaemic coronary artery disorders, tachycardia, haemorrhage, thromboembolic and ischaemic events, peripheral vascular disorders, vascular hypertensive disorders, dyspnoea, parenchymal lung disorders, pleural effusion, pharyngitis, cough, nasal congestion and inflammations, gastrointestinal inflammatory conditions, gastrointestinal ulceration and perforation, gastrointestinal haemorrhages, stomatitis, ascites, vomiting, gastrointestinal and abdominal pains, constipation, flatulence, bloating and distension, loose stools, hepatic enzymes and function abnormalities, cholestasis and jaundice, hepatocellular damage and hepatitis, cholangitis, pruritus, rash, alopecia, acne, sweating increased, arthralgia, muscle cramps, limb and back pain, renal failure, oliguria, renal tubular necrosis, nephropathy toxic, bladder and urethral symptoms, asthenic conditions, febrile disorders, oedema, blood alkaline phosphatase increased, weight increased, body temperature perception disturbed, primary graft dysfunction. **Uncommon (>1/1000 to <1/100):** coagulopathies, coagulation and bleeding analyses abnormal, pancytopenia, hypoproteinaemia, hypophosphataemia, hypocalcaemia, coma, central nervous system haemorrhages and cerebrovascular accidents, paralysis and paresis, encephalopathy, speech and language disorders, amnesia, cataract, arrhythmias, cardiac arrest, heart failures, cardiomyopathies, infarction, deep venous thrombosis, shock, respiratory failures, respiratory tract disorders, asthma, paralytic ileus, peritonitis, acute and chronic pancreatitis, anuria, haemolytic uraemic syndrome, uterine bleeding, psychotic disorder, multi-organ failure. **Rare (>1/10,000 to <1/1000):** thrombotic thrombocytopenic purpura, blindness, neurosensory deafness, pericardial effusion, acute respiratory distress syndrome, subileus, pancreatic pseudocyst, hepatic artery thrombosis, venoocclusive liver disease, toxic epidermal necrolysis (Ljell's syndrome). **Very rare (<1/10,000 including isolated reports):** hepatic failure, bile duct stenosis, Stevens Johnson syndrome, nephropathy, cystitis haemorrhagic, Neoplasms. Consult the SPC for complete information on side effects and full prescribing information. **Package Quantities, Basic NHS cost & Product licence numbers:** ADVAGRAF<sup>®</sup>/PROGRAF<sup>®</sup>: 0.5 mg capsules x 50 = £40.57 (EU/1/07/387/002)/£63.13 (PL 13424/0004), respectively 1 mg capsules x 50 = £81.14 (EU/1/07/387/004)/£81.90 (PL 13424/000), respectively 1 mg capsules x 100 £162.28 (EU/1/07/387/006)/£163.78 (PL 13424/0001) respectively. 5 mg capsules x 50 £405.71 (EU/1/07/387/008)/£302.56 (PL 13424/0002), respectively. **Legal Classification:** POM. **Date of Revision:** April 2009. Further information available from Astellas Pharma Ltd, Lovett House, Lovett Road, Staines TW18 3AZ. ADVAGRAF<sup>®</sup> and PROGRAF<sup>®</sup> are registered trade marks. For medical information phone 0800 783 5018

Adverse events should be reported.  
Reporting forms and information can be found at [www.yellowcard.gov.uk](http://www.yellowcard.gov.uk). Adverse events should also be reported to Astellas Pharma Ltd – 0800 783 5018

**astellas**  
Leading Light for Life

## Summer promotion for SkinSure range

SkinSure International (SSI) will be promoting its SkinSure products for the first time this summer after acquiring the brand earlier this year. SkinSure Plus and Ultra will be promoted with leaflets and sampling activity at London Underground stations during August.

SkinSure Plus (1 per cent triclosan) has an antimicrobial action and soothing, moisturising and barrier properties. It is associated with an antibacterial spectrum covering *Staph aureus* including MRSA, *E. coli* including VRE, *C. difficile* in vegetative form, salmonella and shigella, according to SSI.

SkinSure Ultra (2 per cent triclosan) is designed for severe infections. SSI says the product is suitable for people with chronic illness who require frequent hospital admission and have become

colonised by MRSA. The product can be used to clear them of colonisation, allowing their operations to go ahead, claims the company.

Both products are available on FP10 and are obtainable from major wholesalers. Introductory offers for pharmacies are available from distributor GP Supplies.

**Prices:** Plus £5.99/100ml, £7.99/200ml, £15.99/500ml; Ultra £6.99/100ml, £8.99/200ml  
**GP Supplies; tel: 0845 458 4040**  
[www.skinsure.co.uk](http://www.skinsure.co.uk)



## SaniGuard targets hospital bugs

SaniGuard's new anti-infection kit is designed to protect hospital patients and visitors from MRSA, norovirus, swine flu, *E. coli* and other hospital-acquired infections.

The PatientGuard kit includes two dry-on-contact sanitising sprays suitable for use on hospital bed linen, curtains and other 'near patient touch sites'. The pack also contains an alcohol-free hand sanitiser and five single-use

sanitising hand wipes.

The launch coincides with the release of new figures from the Health Protection Agency on ward closures due to norovirus, which show a 23 per cent increase on the same period last year.

**Price: £9.78**  
**SaniGuard International**  
**Tel: 0800 334 5781**  
[www.killoncontact.com](http://www.killoncontact.com)

## Boost for Viviscal supplement

Viviscal natural hair loss supplement is being supported with a national advertising campaign in newspapers and women's interest and health magazines this summer. In addition, posters and leaflets for the brand are in 3,000 GP surgeries around the country.

Hair Loss Awareness month in May generated a 175 per cent increase in sales of the supplement (May-June on

March-April), according to Lifes2good. The initiative was fronted by the launch of a new piece of academic research, directed by Dr Nigel Hunt of The University of

Nottingham, which revealed a range of serious psychological issues that affect sufferers. The report is at [www.managinghairloss.com](http://www.managinghairloss.com), an online resource launched by Viviscal.

"The report and the website have enabled us to provide trusted in-depth information and advice, which has driven footfall and sales for our partner retailers," says Nigel Herman, sales director at Lifes2good.



**Lifes2good**  
**Tel: 01923 852790**

## New strength adds to Sandocal+D offering

Following the launch of Sandocal+D 600 earlier this year, Novartis Consumer Health had introduced effervescent tablets with higher strength calcium and vitamin D<sub>3</sub>.

Available at the end of July, Sandocal+D 1200 effervescent tablets contain 2,716mg calcium lactate gluconate, 2,100mg calcium carbonate (equivalent to 1,200mg calcium) and 8mg colecalciferol (equivalent to 800 IU 20µg vitamin D<sub>3</sub>). The dosage for adults and adolescents is one tablet daily.

The pharmacy-only tablets are for

the prevention and treatment of calcium and vitamin D deficiency and as an adjunct to specific therapy in the prevention and treatment of osteoporosis for those at risk of calcium and vitamin D deficiency.

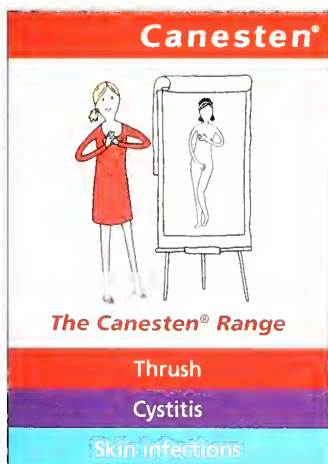
Like Sandocal+D 600, the 1200 tablets have an orange flavour and should be dissolved in a glass of water (approximately 200ml) which should be drunk immediately.

**Price: £4.32/30**

**Novartis Consumer Health**

**Tel: 01403 210211**

## Canesten guide gets intimate



The guide covers triggers, symptoms and treatment of thrush, symptoms and treatment for cystitis and advice on fungal skin infections such as athlete's foot and sweat rash.

"With this advice on hand, pharmacy staff will be able to engage women in a brief advice session that will help them find the right treatment," said a Bayer spokesperson.

The company is distributing 18,000 copies of the guide to pharmacy staff, with additional copies available on request.

Sales of Canesten Duo have grown by 15.1 per cent year-on-year and it is the leading thrush treatment brand in the UK in value sales, with 21.9 per cent market share in pharmacy (IRI chemists value sales 52 w/e 16 May '09).

**Bayer Consumer Care**

**Tel: 01635 563524**

**www.canesten.co.uk**

Bayer has produced a Canesten guide for pharmacy assistants, designed to help minimise embarrassment when talking to female customers about intimate health issues.

The Canesten Consultation Guide comprises five glossy cards designed to provide a quick reference to different Canesten treatments.

## Dermovate-NN makes a return

Chemidex is relaunching Dermovate-NN Cream and Ointment in 30g sizes.

The company acquired the licences for the products after the brand was discontinued by GSK.

Dermovate-NN contains the highly active topical corticosteroid clobetasol propionate, which can be used in short courses for the treatment of recalcitrant eczemas, neurodermatoses and other conditions that do not respond satisfactorily to less active steroids.

Suitable for adults and children aged over two years, the products should be applied sparingly to the affected area once or twice daily until improvement occurs.

Treatment should not be continued for more than seven days without medical supervision.

The products are now available from all wholesalers.

**Pip codes: 30g cream 014-2455;**

**30g ointment 014-2976**

**Chemidex Pharma**

**Tel: 01784 477167**

**www.chemidex.co.uk**

# Eurax

## One Solution



## Summer Skin Ailments

Summer time brings outdoor activities, kids playing and exposure of skin. For families, Eurax is a medicine cabinet essential, bringing relief to the itching and skin irritation caused by insect bites and stings, sunburn, heat rash and nettle rash.

- No.1 Selling product in the anti-itch market\***
- The only product to contain crotamiton**
- Helps Stop itching fast**
- Up to 10 hours relief**

## Trust Eurax

for 10 different skin irritations

- ✓ Itchy dermatitis
- ✓ Dry eczema
- ✓ Allergic rashes
- ✓ Insect bites & stings
- ✓ Hives
- ✓ Nettle rash
- ✓ Heat rash
- ✓ Sunburn
- ✓ Chickenpox
- ✓ Personal itching



Legal Category: GSL

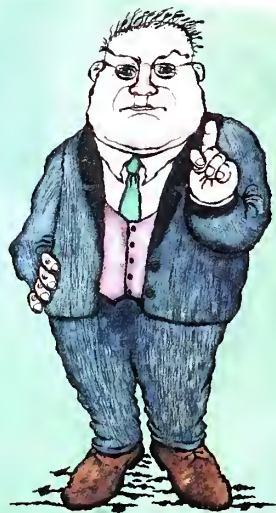
For more information contact the PL holder:  
Novartis Consumer Health, Horsham, RH12 5AB.

\*Source: IRI Chemists including Boots and Superdrug, 52 w/e 21 Mar 2009, Value Sales

Contains Crotamiton

**NOVARTIS**

# Even my customers are against me



‘THE GENERAL PUBLIC SEEM TO BE GETTING MORE FRUSTRATING, IGNORANT, RUDE AND STUPID BY THE DAY’

This must indeed be the loneliest profession. In our uniquely combined role of NHS contractor and shopkeeper, here to supply whatever the doctor orders and providing services free at point of delivery, we are probably the least appreciated by our clients. At a time when I feel like I'm walking a tightrope between survival and nervous breakdown, it could be stroppy customers that push me over the edge.

The C+D Senate (C+D, July 11, p20) pontificated from a safe distance about some of the more newsworthy issues that I battle with on a daily basis but they failed to mention that constant gripe – the general public. It could just be me, or it could be the heat, but they seem to be getting more frustrating, ignorant, rude and plain stupid by the day.

Over the last couple of weeks I've had requests for stamps, newspapers, Interflora, and the use of our phone to ask the pet shop if they've got any hay left. I've heard of the one-stop shop concept, but this is ridiculous.

Even during the most difficult times, a few good manners go a very long way. We work extremely hard to be courteous and pleasant to everyone who walks through the door, but 'please' and 'thank you' seem to have been dropped from many customers' vocabulary.

And the more you do for people, the worse they

get. Beneficiaries of our free, world-class delivery service are some of the most frustrating to deal with. All they're required to do is to answer the door when the delivery driver rings. He calls at roughly the same time every day, and if they're not at home one day he'll call back the following day at no extra charge. If they're out shopping or asleep, they have to wait till tomorrow. I'm too long in the tooth to be making deliveries after work to lazy, selfish ingrates. We will not deliver anything that doesn't originate from this pharmacy, and we will not perform household chores while making a delivery.

The only customer I've seen in the past few weeks who showed me the slightest gratitude or consideration was a man collecting Tamiflu for a member of his family. At least I think it was a man – he had his jacket wrapped around his head to prevent any viruses from travelling in my direction so I couldn't really tell. He certainly swore like a man when he tripped over the corner of the gondola end because he couldn't see much through the fabric of his jacket. I was touched by his efforts, but had to tell him they were probably in vain as I'm bound to catch the flu sooner or later anyway.

If only more of my customers were like this man. And a little consideration needn't cost them a grazed shin, like it did in this case.

# Let's get a move on with disciplinary hearings

C+D recently reported that the RPSGB is spending £200,000 on more sitting days for the disciplinary committee in order to reduce the delays before cases are heard (May 30, p10). This is welcome.

The Society's treasurer attributed delays to the increasing complexity of cases and new procedures for disciplinary hearings. He is only partly right.

My oldest case has just come to an end. It started over 15 years ago. Disciplinary cases usually start with the Registrar, who passes on complaints to an investigating committee. This committee should decide whether to refer a case to the disciplinary committee.

The Pharmacists and Pharmacy Technicians Order says that if more than five years have passed since the last event complained of, a case cannot be passed to the disciplinary committee unless the Society's Registrar certifies that

referral would be necessary for the protection of the public, or is in the public interest. However, it appears that Society staff routinely overlooked the five-year rule and passed my case (and others) to the investigating committee, which then referred them to the disciplinary committee.

Once I pointed out that there was no sign of the Registrar having given a certificate, the case had to be sent back to the investigating committee for its earlier decision to be rescinded. The case was then sent back to the Registrar.

Wisely, the Registrar decided it was not necessary for the protection of the public or in the public interest for the case to be referred. However, from the time I pointed out the case was more than five years old until the Registrar decided the case should not go any further took another 17 months.

My 15-year-old case is not an

isolated instance of delays before cases are referred to the disciplinary committee. For example, I have clients who were investigated three years ago, and still do not know when the investigating committee will consider whether to refer them to the disciplinary committee.

I applaud efforts by the Society to reduce the delays in cases waiting to be heard by the disciplinary committee, but something needs to be done about the length of time it takes from the conclusion of an investigation to when the investigating committee decides how the case should be dealt with.

I hope the Society will take action to deal with delays at the start of the disciplinary process, not just at the end of it.

**David Reissner is a solicitor and head of healthcare at Charles Russell LLP, where he is a partner**



‘MY 15-YEAR-OLD CASE IS NOT AN ISOLATED INSTANCE OF DELAYS’

# Brandfocus

## Improving the UK's health and quality of life

How would you like to be able to offer your customers intelligent, reliable and simple-to-use self-monitoring products that let them to monitor their health from home?

The self diagnostics market is a growing category worth over £100 million and rising. A new home health monitoring range from Proton Healthcare has been designed to help people take positive control of their health and set new standards in accuracy and precision.

Each product offers professional standard precision monitoring and consumers benefit from a comprehensive support package.

Proton Healthcare is supporting the launch with a seven figure marketing campaign that includes print, TV and online advertising, plus an extensive PR campaign to educate consumers about the role and benefits of home health monitoring and drive footfall into pharmacies.

### Digital blood pressure monitors

Five wrist band and four upper arm monitors are available. The easy-to-use Proton PHC 888UP digital upper arm blood pressure monitor is simply wrapped around the left upper arm, the on/off switch pressed and it gets to work. It can store up to 99 readings of systolic and diastolic pressure, plus the pulse rate, displayed on an easy-to-read screen. The monitor comes with four AA alkaline batteries, a storage pouch and instructions. **Cost: £54.99**



### Digital Thermometers

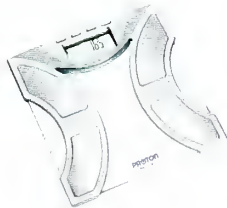
The Proton range of thermometers includes five digital and infra-red ear thermometers. The Proton PHC 889 digital ear thermometer calculates temperature in just two seconds and has a fever alarm to alert users to particularly high readings. A safe and comfortable ear probe comes with 20 extra covers for other family members. Readings are in Centigrade and Fahrenheit and a nine-memory recall option allows users to recall or compare temperatures. The thermometer comes with batteries and a durable case. **Cost: £39.99**



PROTON

### Body Fat Analyser Scales

Proton products provide up-to-the-minute precise ways for people to stay fit and healthy, and to look good. The Proton PHC 511BF body fat and hydration scale uses the latest technology to measure both body weight and body fat ratio. It sends a safe, low-level electrical signal through the body and measures the speed at which it is conducted by body water, as it passes more quickly through lean tissue than fat due to its lower percentage water content. The results are displayed on a digital LCD screen and up to eight user IDs can be stored. **Cost: £79.99**



**Ceuta Healthcare:**  
**Tel: 01202 780558**

[www.protonhealthcare.co.uk](http://www.protonhealthcare.co.uk)

**PROTON**  
bringing good Healthcare

18.07.09

# Features

## Responsible Pharmacist

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How to operate the pharmacy when the RP is absent



## Update: July is Heart Health Month



The third of four articles looks at treating BP

## Practical Approach



Two years qualified and burnt out with stress: where can Salma go for help?

## Burden of proof



How research can be of great benefit to you and your patients

## Northern stars



Two case studies show how a project in Northern Ireland is improving local health

## Jobs



Studying to become a pharmacist prescriber can open up long-term career benefits

# The Responsible Pharmacist

**The Responsible Pharmacist (RP) regulations include an allowance for RPs to be absent from the pharmacy premises for up to two hours in one day. But it's not as simple as just walking out the door.**

## PART 5 Absence of the responsible pharmacist

Under existing legislation, it is generally accepted that if there isn't a pharmacist available to be in "personal control" then a pharmacy may not open. The new RP regulations will enable a pharmacy to operate in a limited capacity in the absence of the RP. However, if a second pharmacist is not available, only GSL medicines may be sold, prepared POM medicines must not be handed out and P medicines may not be sold.

An RP (whether or not they change throughout the day) may be absent for a cumulative maximum of two 'business hours' within any 24-hour period (from midnight to midnight). These 'business hours' are

hours in which the pharmacy is operational. This has been interpreted by the DH and RPSGB to include times when the pharmacy is not open to the public but when activities such as preparing prescriptions or ordering medicines might be taking place.

The intention is to allow a pharmacist to run services or attend work-related meetings while allowing the pharmacy to continue to operate legally. It is not mandatory to be absent and RPs must be able to exercise their professional judgement on whether to use the provision. For the pharmacy to operate safely and effectively when the RP is absent, you'll need to

ensure there are SOPs in place that define operations during this time. The RP remains responsible for the activities undertaken when he or she is absent, namely the sale of GSL medicines. Remember, when the RP is absent only GSL medicines may be sold, prepared POM medicines must not be handed out and P medicines may not be sold. With the exception of Northern Ireland, there will be a professional requirement to record the reason for absence.

When absent, the RP should be contactable where possible and be able to return to the pharmacy reasonably promptly where necessary. If this is not possible then you must arrange for another pharmacist to be available to give advice (perhaps remotely) to staff.

The NPA's comprehensive SOP – Operating in the Absence of the Responsible Pharmacist – can be

## Absence checklist

1. Ensure the pharmacy can run safely, and that staff know what they can and can't do in your absence.
2. Record the date and time of the absence in the pharmacy record.
3. Remain contactable or ensure another pharmacist is contactable.
4. Be able to return with reasonable promptness.
5. Remember the cumulative maximum that RPs may be absent for is two hours.

downloaded at [www.responsiblepharmacist.com](http://www.responsiblepharmacist.com). This provides further details on the conditions for being absent and what remaining pharmacy staff can or cannot do. **PART 6 Focus on superintendent pharmacists, in C+D, August 1.**

Don't quite know where the Responsible Pharmacist regulations will leave you? The NPA's head of information Michelle Styles is on hand with the answers. Email [haveyoursay@cmpmedica.com](mailto:haveyoursay@cmpmedica.com) and see FAQs at [www.responsiblepharmacist.com](http://www.responsiblepharmacist.com)

The C+D and NPA Responsible Pharmacist Toolkit is supported by McNeil Products Ltd



## Grow your business with the world's best-selling animal health brand.

FRONTLINE® Spot On provides long-lasting protection against fleas, ticks and lice for cats and dogs. And now it's been reclassified as an NFA-VPS (similar to a P human medicine classification) it provides you with a huge sales opportunity.

- An estimated 500,000 pet owners visit a pharmacy every day\*
- The pet ectoparasiticide market is worth £113 million\*\*
- FRONTLINE Spot On sells more than twice as much as its nearest rival.†

Order your stocks now through Alliance Healthcare, Sigma on 0800 597 4462 or EVS Direct on 01926 408692.

For more information please call us on **0870 6000 123.**

FRONTLINE® is the world's best-selling animal health brand. Source: Vetnosis.

\* Resource Pack NPA \*\* Pet accessories and healthcare market intelligence, Mintel, Sept 2008.

† GfK – UK companion animal ectoparasiticide market, Dec 2008.



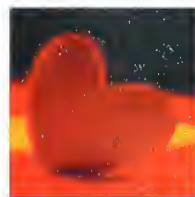
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# Update



## July is Heart Health Month

Throughout July C+D presents its own Heart Health Month with four articles on topics in CVD medicine that describe the heart disease epidemic, risk assessment, and hypertension and cholesterol treatments. See the articles online at [www.chemistanddruggist.co.uk/update](http://www.chemistanddruggist.co.uk/update)

Your weekly CPD revision guide

Module 1486

# CVD guide part 3: treating BP

Update's Heart Health Month continues with a focus on drugs that might be prescribed after an NHS Health Check

## 60-second summary

### How is blood pressure control achieved?

About half of patients will need more than one drug to reach the target of 140/90mmHg (or 130/80 mmHg in diabetes, atherosclerotic CVD or chronic renal failure). NICE recommends a stepped approach using combinations of ACE inhibitors (or angiotensin-II inhibitors), calcium channel blockers and diuretics. Beta-blockers have fallen out of favour in all but a few circumstances.

### Should treatment be for life?

Not necessarily if patients are prepared to make lifestyle adjustments, have low CVD risk and their BP has been brought under control.

This article (Module 1486) can help in the following CPD competencies: G1a, G1c, G1d, G1e, C1a, C1b, C3e.  
See <http://tinyurl.com/68ox7b>

### Rosemary Blackie MRPharmS

This article and the next in our Heart Health Month consider two groups of drugs that might be needed following vascular risk assessments – antihypertensives and cholesterol-lowering agents. The two previous articles in this series looked at lifestyle factors affecting the heart and how pharmacists can assess people for vascular disease risk.

NICE published updated guidelines for treatment of hypertension in 2006, but patients may still be taking medication as advised by previous guidelines. As long as blood pressure is controlled, there is no absolute need for change. Indeed, where there is a compelling indication for medication such as beta-blockers they should not be withdrawn.

Guidelines are guidelines, not laws, and individual patient factors should be taken into account. However, the GP should be contacted if there are concerns. Whenever changes are made, the patient should be fully informed of the reasons and changes initiated in a controlled manner, with appropriate monitoring.

### Hypertension

The guidelines are summarised in MIMS. The aim is to reduce BP to less than 140/90mmHg, or less than 130/80mmHg in diabetes, atherosclerotic CVD or chronic renal failure.

As great a reduction as possible is acceptable, even if the target is not reached. Some 50 to 75

per cent of patients achieve their target,<sup>1</sup> but about 50 per cent will need more than one drug.<sup>1</sup>

Once-daily medication has been shown to result in about 90 per cent compliance compared with significantly lower adherence levels for twice daily or more frequent dosing.<sup>2</sup> Blood pressure can be monitored at home to ascertain the results. Review should be at least annually.

Treatment should be offered where:

- BP is consistently over 160/100mmHg
- there is isolated systolic hypertension over 160mmHg
- the CVD risk is higher than 20 per cent and BP is over 140/90mmHg
- there is existing CVD or target organ damage and the BP is persistently over 140/90mmHg.

Treatment follows a stepped approach according to the ACD rule (see Table 1 below). It acknowledges that genetics affect outcome, eg Caucasians under 55 respond better to ACE-inhibitors and angiotensin-II antagonists than Afro-Caribbeans of the same age.

Medication should be added sequentially if BP does not respond, with intervals of four weeks between each change, and compliance ascertained. Switching to alternatives within the same class can also be beneficial.<sup>2</sup> It is recommended that a selective alpha-blocker, beta-blocker or another diuretic is considered as well as specialist referral if BP is not controlled on three drugs.<sup>1,2</sup>

There is less evidence for antihypertensives in the elderly (over 80 years) because there are few studies. However, the benefit of treating

Table 1: NICE recommendations for combining BP lowering drugs

	Younger patients (under 55 years)	Older (55 or over) or black patients of any age
Step 1	A	C or D
Step 2	A + C	A + D
Step 3	A + C + D	A + C + D
Step 4	Add further diuretic therapy or alpha-blocker or beta-blocker	

A = ACE inhibitor or angiotensin-II antagonist. C = calcium channel blocker. D = diuretic

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hypertension in the elderly is greater as they are at greater risk of CVD.<sup>2</sup> The threshold for starting treatment is higher (over 160/90mmHg) than in younger patients.

If benefits outweigh risks and side effects, treatment should be initiated or continued. Treatment need not be life-long if the patient makes lifestyle modifications, has low CVD risk<sup>2</sup> and has controlled BP with treatment.

## Diabetes

BP control gives macrovascular protection, whereas good glucose control gives microvascular protection. ACE-inhibitors are thought to have renoprotective effects. ACE-inhibitors or thiazides are first line in this group.

## Aspirin

Aspirin 75mg daily is recommended for those:

- with established CVD eg MI, angina, hypertension
- with a 10-year CVD risk higher than 20 per cent and over 50 years as long as the blood pressure is controlled to less than 150/90mmHg.<sup>2</sup> Aspirin should be taken with food and those who need gastro-protection should be offered a PPI.

## ACE-inhibitors and angiotensin-II antagonists

ACE-inhibitors inhibit conversion of angiotensin-I to angiotensin-II by blocking the converting enzyme in the kidney. This reduces water re-absorption, dilates blood vessels and reduces aldosterone production. Bradykinin breakdown is inhibited, so kinin and PGE<sub>2</sub> accumulate in the airways, causing a dry cough side effect. This can last some time after ACE-inhibitor cessation.

Typical doses are 8 to 32mg once daily for candesartan and 50 to 100mg once daily with losartan. Starting at a low dose and taking at night helps to avoid hypotensive effects.

Renal function and electrolytes should be checked before and during initiation as side effects are more likely in impaired renal function.

NSAIDs and ACE-inhibitors should be avoided together as this increases risk of renal failure. Care should also be taken when using potassium-sparing diuretics with ACE-inhibitors because of increased hyperkalaemia risk. Angiotensin-II antagonists can be used in ACE-inhibitor intolerance.

## Calcium channel blockers

For a period it was thought CCBs may lower BP but increase CV risk. However, newer trials (ASCOTT, ALLHAT and others) have alleviated these concerns.<sup>2</sup> All CCBs interfere with calcium ion entry into cells through the slow channels so there are fewer calcium ions for the contractile proteins. However, the individual drugs vary in their effects:

- **Dihydropyridines** eg amlodipine, nifedipine, affect the cardiac and vascular smooth muscle without adversely affecting the myocardium, ie they do not worsen heart failure or reduce myocardial contractility. They reduce systemic vascular resistance by peripheral arteriole dilation and reduce left-ventricular work. Perfusion into normal and ischaemic myocardial muscle is improved. They have a slow onset of action so acute hypotension is less likely.

- **Phenylalkylamines** – verapamil reduces heart rate and has negative inotropic effects, which is why it should not be used with beta-blockers. It also reduces peripheral resistance and vasodilates.

- **Benzothiazines** – diltiazem peripherally dilates and reduces cardiac load but cardiodepressant effects are less than those of verapamil. It is extensively metabolised by the P450 3A4 system, causing increased concentration with inhibitors and reduction with inducers. It also itself inhibits P3A4 so can increase levels of benzodiazepines, carbamazepine and theophylline.

See C+D online for Table 2, which summarises dose, side effects and interactions.

## Diuretics

There are several classes, but the thiazides are indicated in guidelines. They block reabsorption of sodium and chloride ions in the renal tubule to reduce water retention, so reducing blood volume. Overall, peripheral resistance is reduced.

The main problem is their diuretic effect. If taken at breakfast, this is over by late morning. Patients can be advised to alter dose timing to increase journey comfort when travelling.

The usual dose for bendroflumethiazide is 2.5mg in the morning. Increasing the dose increases side effects, including hypotension and aggravation of gout, with little effect on BP.

## Beta-blockers

Blocking beta<sub>1</sub> receptors reduces cardiac work. Oxygen supply is improved by reducing heart rate and blood pressure to decrease end systolic stress and contractility, and by prolonging diastole to increase coronary flow. Exercise tolerance is increased and peripheral adrenoceptors are blocked.

BBs should be avoided in asthma as they can cause broncho-constriction. They also mask hypoglycaemic signs in diabetes. Atenolol is the better preparation if BBs are definitely indicated.

BBs fell from favour in hypertension treatment partly because they were found to precipitate diabetes when used with thiazide-like diuretics.<sup>1,2</sup> They are also less effective than other drugs in reducing stroke risk.<sup>2</sup> A lower dose is usually required for hypertension than for angina. However, they can be considered for younger people in certain situations, such as women of child-bearing potential or where there is intolerance to ACE-inhibitors or angiotensin-II antagonists. Nice recommends that where BP is well controlled with BBs then there "is no absolute need to replace the beta-blocker".

BBs should be withdrawn over four weeks to avoid angina, rebound hypertension and MI.

Side effects include sleep disturbance and other CNS effects. These can be reduced by using hydrophilic compounds, such as atenolol, as these pass through the blood-brain-barrier much less.

Sexual dysfunction, fatigue and peripheral

neuropathy are other side effects. All can be reduced by lowering doses.

## Alpha-blockers

These inhibit alpha-one adrenoceptors at post-synaptic sites to cause peripheral vein and arteriole dilation. They are recommended as a fourth drug, if needed. Care is needed in patients taking preparations for BPH.

Severe first dose hypotension can be a problem, with other possible side effects, including GI upset, oedema, constipation and palpitations. Modified release preparations, such as doxazosin, are indicated for once-daily dosing. They reduce BP, but there is little evidence to support their use.<sup>2</sup>

## Vasodilators

Vasodilators, such as hydralazine, are not mentioned in the guidelines. They act centrally to exert vasodilatory effects on the arterioles, reducing peripheral resistance and BP. They are usually taken twice daily.

## Renin inhibitors

Aliskiren (Rasilez) is the only medication available in this class. It directly inhibits renin, so acts higher in the renin-angiotensin system than the other anti-hypertensives by blocking the conversion of angiotensin to angiotensin I; it also reduces levels of angiotensin I and angiotensin II. Another difference between it and other medications acting on this system is that there is no compensatory increase in plasma renin activity.<sup>5</sup> It has been shown to reduce both systolic and diastolic blood pressure,<sup>5</sup> but the Scottish Medicines Consortium has not identified a place in treatment for aliskiren as there is not enough data.

It can be used alone or as combination treatment, with the most common side effect being diarrhoea. It should be taken with a light meal, but not high fat, as this can reduce availability by up to 70 per cent.<sup>5</sup> Avoidance of grapefruit juice is advised because the effect of this is unknown.

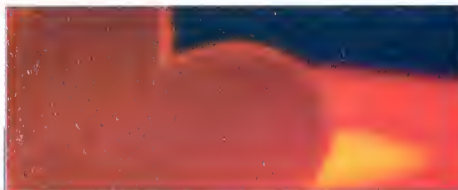
## Combined preparations

Combined preparations have the advantage of reducing the number of tablets required. Where a patient has been stabilised on two different tablets, then a combination can be trialled, but there are few combinations including with the most common hypertensives, such as atenolol and bendroflumethiazide.

**Rosemary Blackie is a community pharmacist in Sheffield.**

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References and further information are online at [www.chemistanddruggist.co.uk/update](http://www.chemistanddruggist.co.uk/update)



**NEXT WEEK'S UPDATE**  
CVD guide part 4: The drugs used to lower cholesterol

## CVD guide part 3: anti-hypertensive medication

## Reflect

What is the first choice drug treatment for hypertensive patients under 55? How do calcium channel blockers work? What are the side effects of beta-blockers?

## Plan

This article describes the guidelines for the treatment of hypertension including treatment thresholds and recommended drug regimes. The actions, doses and side effects of the drugs used are discussed.

## Act

Read the full version of this article on the C+D website at [www.chemistanddruggist.co.uk/update](http://www.chemistanddruggist.co.uk/update)

Read the two preceding articles on cardiovascular risk and assessment (also on the C+D website) if you have not already done so. Make a note to read next week's article on cholesterol-lowering medication.

For more information about hypertension treatment read the British Hypertension Society guidelines at [www.bhsoc.org](http://www.bhsoc.org)

Further revise your knowledge of anti-hypertensives by reading section 2.5 Hypertension in the BNF.

Useful information can also be found in the C+D MUR Zone at <http://tinyurl.com/nk7p9e>. Could any of your patients on anti-hypertensive medication benefit from an MUR?

## Evaluate

Are you familiar with the recommended drug treatment of hypertension? Are you confident in your knowledge of the drugs available? Could you discuss treatments with a patient?

## Practical Approach

## Workplace pressure and stress



Salma Hussain, formerly pre-registration trainee pharmacist at the Update Pharmacy, has received a call from Nadia, her friend from university who now works for a large community pharmacy multiple. Nadia sounds distressed and wants to meet Salma urgently.

"What's the problem?" Salma asks when they meet.

"I've been qualified just two years and feel burned out already," Nadia

replies. "I'm totally stressed out at work and feel I just can't take much more."

"Why's that?" Salma asks.

"It's the workload and pressure to meet targets, and the fact that the company just seems to regard me as a profit generation operative."

"I'm expected to deal with a constant stream of prescriptions, as well as advise patients, deal with queries, supervise sales, meet MUR quotas, and do smoking cessation and other clinical services. Plus I've got all the governance red tape and company paperwork to cope with."

"I can't take proper rest or meal breaks, because I'd just come back to a backlog and a queue of disgruntled customers," says Nadia.

"Have you taken this up with the company?" says Salma.

"I just get nowhere. The area manager's always on my back, telling me I'll get a bad annual appraisal unless I meet my targets. When I complained to head office they just referred me back to the area manager."

"I feel I can't take any more, Salma. Tell me what I can do. Should I complain to the Pharm Soc?"

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## Questions

1. Could or would the RPSGB do anything about Nadia's situation?
2. What other advice could Salma give?

## Answers

1. The Royal Pharmaceutical Society's Code of Ethics does not have any standards or guidance dealing directly with conditions or situations that might give rise to stress. However, Professional Standard 2.1 requires pharmacists in positions of authority to ensure their policies "ensure the safe and effective provision of pharmacy services", while Standard 4.4 requires them to ensure that "working conditions and practices... enable staff to provide services to professionally acceptable standards". Standard 4.5 deals with rest breaks and 7 is about enabling staff to raise concerns. It could be argued that working conditions that lead to stress, and possibly error as a result, are not in accordance with these standards. It is not known whether a complaint has ever been made to the Society on these grounds and,

if so, what action the Society took.

2a) Consider a change of employer, although there is no guarantee that working for another one would be less stressful.

b) Working as a locum may give Nadia more control over her situation and prove less stressful.

c) Contact Pharmacist Support's Listening Friends' stress help service. It is free and provides a sympathetic 'listening ear' from trained volunteer pharmacists and an opportunity to talk through possible options. Counsellors can also refer callers to sources of expert advice.

d) Join a pharmacist employees' representative organisation, such as the Pharmacists' Defence Association. It may be able to take up Nadia's case with her employer.

This article can help with these CPD competencies: G1g, G1h, G2j, G2k, G3k, G3l, G4a, G4f  
See <http://tinyurl.com/68ox7b>

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Evidence is needed to support pharmacy's venture into front line NHS care – but what are the rewards for taking part in research, asks **Gavin Atkin**

# The burden of proof

Community pharmacy in the UK must deliver a mass of hard, new research if it is to extend its role in the way government and many in the profession want to see. So said a blockbuster report co-authored by two pharmacy professors and published by pharmacy public health campaign group PharmacyHealthLink in March.

A few weeks later, the Pharmacy Practice Research Trust (PPRT) stepped up to the podium to call for a multi-million pound investment in research to provide the 'robust evidence' needed to meet the aspirations of pharmacy in the future.

More recently the PPRT announced it had widened the eligibility criteria for some of its research grants to community pharmacy. The deadline for the next round of bursaries is September 25.

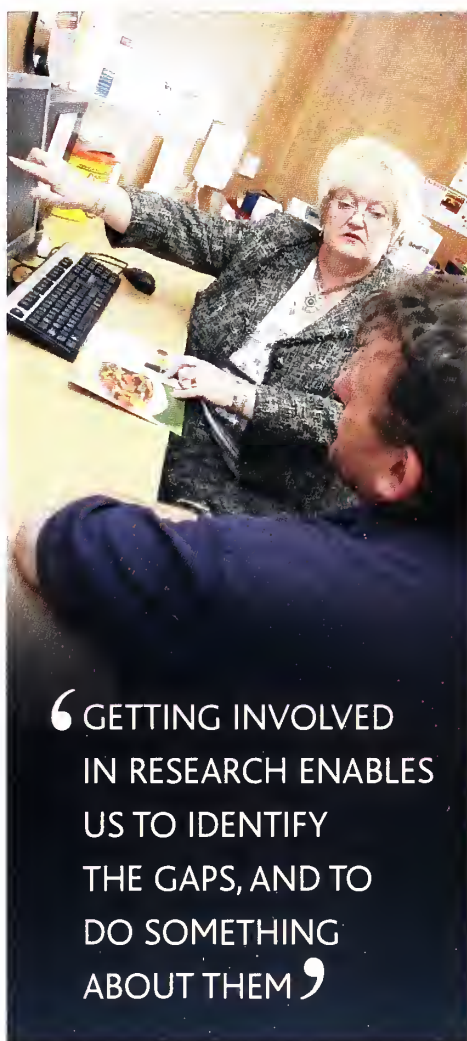
But all this activity begs a big question: if the average pharmacist sees research as only for the academically ambitious, and likely to involve hard work, long hours and probably some cost to pharmacy income, who is going to do the work?

What's needed is a sea change in the way research is viewed, for while pharmacists developing services need hard evidence to make cases for projects, what does the individual pharmacist or pharmacy get out of research?

Listening to pharmacy researchers, it's clear that it can be interesting and satisfying. Specialist pharmacist and PhD student Ranjita Dhital now works for the public health directorate of NHS Lambeth/King's College London, but began her research career in community pharmacy. Ms Dhital won a PCT grant for a project that would train pharmacists to screen patients for risky levels of drinking and provide brief interventions.

Ms Dhital got great satisfaction when the project was a success – she was delighted to discover patients were very interested in a questionnaire she was using to identify drinking consumption levels, and she enjoyed producing patient leaflets to go with the scheme. Ms Dhital has gone on to develop her project further, initially as part of an MSc and now a PhD.

What added interest for her in her later MSc project was the realisation that after practising in



community pharmacy for less than two years, she was already involved in exploring brief intervention training for pharmacists and screening patients in a previously untried project.

Karebor Ngwerume is a community pharmacist in Hull. With the help of a bursary from the PPRT, she has been evaluating a training tool for pharmacy assistants designed to help towards safe selling of OTC medicines.

"I think there are many benefits personally and

professionally from getting involved in research," she says. "Practice should be based on the best available evidence, and getting involved in research enables us to identify the gaps, and to do something about them – and it's satisfying to provide an improved and more professional service as a result."

Research has other benefits beyond improving services, points out PPRT director Sue Ambler: it can contribute to CPD; it might involve local GP practices, which may help to foster good local relations; and of course some people enjoy the intellectual rigour.

She says: "People say research is an ivory tower – but it is often about real issues. A project surveying patients who have been owed medicines because they have been out of stock could be a good place to start.

"It can be your own project, or you can be collecting data for a larger project that might be directed by researchers at a school of pharmacy or a university department of primary care."

If you're interested, there are several routes into research for pharmacists, says Dr Ambler. You can go direct to your local school of pharmacy, there are the local research networks, some areas have pharmacy development groups, and in future there will be the new professional body's local practice forums. Yet another route is to call the PPRT to discuss an idea, check what grants are available and join its researcher mentoring scheme.

Listening to Dr Ambler talking about potential projects – surveying patients, stop smoking, weight management, patients owed medicines – it's striking just how closely the purpose of many research projects matches the needs of pharmacy businesses. "It's about knowing more about your customer base and targeting services," she says. Put that way, the case for research in pharmacy seems too strong to ignore.

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Project manager Anne Faloon (fourth from right) and regulars at the Link Community Centre, which has recruited a community pharmacist to deliver health talks

# Northern stars

A Northern Ireland initiative is funding pharmacists to work in partnership with disadvantaged communities to improve local health. **Max Gosney** sees first hand how two projects are helping to put a smile back on patients' faces



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## Building the Community Pharmacy Partnership (BCPP)

**What is it?** BCPP was launched by Northern Ireland's Community Development and Health Network (CDHN) and funds projects that involve pharmacists promoting health support to the areas they serve. BCPP offers up to £100,000 per year to support pharmacy services aimed at the most disadvantaged sectors of society.

**How does it work?** Pharmacists pitch for funding to help them address a local health need. The BCPP resources projects according to three tiers. Level 1 funding gets projects off the ground, while more sizeable level 3 funding is given once projects show success.

**Does it make a difference?** Yes, over 300 projects have received BCPP funding. The schemes have helped improve sexual health, mental health and diet to name a few. Project manager Sharon Bleakley picked up the retail service of the year prize for the scheme at last month's C+D Awards. Go to [www.cdh.org](http://www.cdh.org) for more information.

### CASE STUDY 1: How a Boots pharmacist helped the homeless

A n emaciated figure with a straggly white beard and a beanie hat tucks hungrily into his mushy peas. On the adjacent table a weather-beaten man looks over a copy of a Belfast newspaper. "Have you seen the Yellow submarine?" he beams, explaining that the contraption is being used as a makeshift water taxi to solve the city's traffic problems. In Northern Ireland, it seems, innovative thinking is a national attribute.

The men, Joe and Tommy, have benefited hugely from a novel partnership between the Link Community Centre in Newtownards, County Down, in which they are sitting, and a local community pharmacist. The centre, run by charity Make a Real Change (MARC), acts as a community hub for those with alcohol and drug addictions. The project sees Boots pharmacist Patricia

Finnegan come to the centre to deliver health talks to addicts. "I was quite nervous the first time I went in," says Ms Finnegan. "I just thought I'd go for it. I was like a wee lamb the first day though."

Ms Finnegan's down to earth approach quickly won her friends. "I thought that formal lectures weren't really appropriate and I think I ended up playing a couple of games of pool that first time just to break the ice."

Having secured the trust of her audience, Ms Finnegan began to bring the addicts health messages on a diverse range of topics. Weekly 15-minute sessions have covered the interactions of alcohol with prescription drugs, oral health, skincare, insomnia and even aromatherapy.

"The relationships Patricia has built up are incredible," says Anne Faloon, the MARC project manager. "We had a community nurse come in at first but it didn't really work out. I think Patricia adopted a much softer approach. It's about getting that balance between professionalism and not coming across as a know-it-all. If they're concerned about anything to do with their health they'll mention it to Patricia."

The pharmacist has bridged a gap with a sector of society the NHS finds hardest to reach. "Often these people don't go to their GP because they're scared," says Ms Faloon. "For them going anywhere to meet anyone is a big deal." Medicine compliance has improved as addicts become aware of the importance of taking their prescription. Ms Faloon adds: "In the past they didn't really care whether they took their prescription or not. Now they understand why they need them; they see the importance of taking them."

The pharmacist's success has been so great that she has built a cult following. Ms Faloon says: "One of the guys has taken to sitting outside the Boots branch where Patricia works." Ms Finnegan says he is often joined by others from the MARC centre. "I see quite a few of them in a professional capacity. The shop staff have built up relationships with them and they feel comfortable here."

Getting addicts into the pharmacy has also resulted in referrals to other parts of the NHS. Some have visited the GP on the back of Ms Finnegan's advice. But it's not only the addicts who have benefited. She concludes: "It's given me the chance to hone my counselling skills. Now I wouldn't be afraid to go into any setting. It's reinforced my role as a community pharmacist rather than just a pharmacist who works in Boots."

#### CASE STUDY: Bringing seaside glamour back to Millisle

**M**illisle is Northern Ireland's answer to Blackpool. A popular seaside resort that has fallen on hard times since the dawn of cheap holidays to the Med. Local residents have borne the brunt of the town's decline, particularly in respect of their health, says resident community pharmacist Alana Miller. "We have a high level of antidepressants. Over 40 per cent of school leavers have no qualifications. Often several generations of the same family are on prescription medicines."

The town may have fallen out of favour with tourists, but its community pharmacist is sticking by its citizens. Ms Miller has been running a series of support projects for local women over the past four years. "If you work in a small community you can't just close up and go home at the end of the day. You have to give something back."

Ms Miller hires out a local hall where she hosts evening health classes that cover subjects from osteoporosis to relaxation techniques. The hope is that attendees spread the health message far and wide, she says. "We aim to improve the health of entire families by working with mums."



Alana Miller: using dance to connect with the locals

The catchment audience is diverse, Ms Miller explains. Women range from 20-somethings to septuagenarians. She says: "Many of the younger women suffer from depression because of the isolation. The older ladies have mobility problems and suffer from long-term conditions."

Persuading a parochial community to air their health concerns in public has taken persistence, Ms Miller reflects. "I mention it to people as they come into the pharmacy. I tell them to come along for a chat." Once they're at the hall with a cup of tea the women quickly relax, Ms Miller says. "At the moment I've got 35 ladies on my list. I've created a monster," she jokes.

The project has helped lift the mood of the locals, Ms Miller says. "They come into the pharmacy chatting about what they were doing at the club and they're much happier." Ms Miller's work has meant local patients are much more candid over their health problems. "I think it's changed. They'll speak to me about queries that they might not have done before."

The class's latest venture has been ballroom dancing. "Dancing is a good way of improving your health. It gets your heart beating and it improves your memory," explains Ms Miller.

And the industrious Ms Miller is not done yet. A pensioners' gym and cooking classes for men are future goals. "If you want something done you ask a busy person. People who have less time to do things are better at finding the time to do them."



‘IT’S REINFORCED MY ROLE AS A COMMUNITY PHARMACIST RATHER THAN A PHARMACIST WHO WORKS IN BOOTS’

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# C+D Stock Survey

Drug shortages have been a persistent drain on resources in 2009. To help us gauge the situation, C+D is asking all our contractor readers to complete and return this questionnaire by August 3

1. On average, how long do you spend trying to get hold of out of stock drugs each week?

- a) Less than an hour  
b) 1-2 hours  
c) 2-5 hours  
d) 5 hours +

☐  
☐  
☐  
☐

2. How many drugs are currently out of stock at your wholesaler?

- a) 0  
b) 1-5  
c) 5-20  
d) 20-50  
e) 50+

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☐

3. Typically how long do you have to wait for an emergency stock delivery when ordered direct from a manufacturer?

- a) 1-2 days  
b) 3 days  
c) 4-5 days  
d) More than 5 days

☐  
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☐  
☐

4. Have you ever practised parallel exporting?

- a) Yes  
b) No

☐  
☐

5. What have been the three most difficult products to get hold of this year?

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6. Has it been easier or harder to get hold of product from manufacturers running reduced wholesaler distribution models?

- a) Easier ☐ b) Harder ☐ c) Same ☐

7. How would you rate the customer service response from manufacturers when you have had to order product direct?

- a) Excellent  
b) Good  
c) Satisfactory  
d) Poor  
e) Very poor

☐  
☐  
☐  
☐  
☐

8. Have you ever asked a GP to change a prescription because of difficulties sourcing the drug in question?

- a) Yes  
b) No

☐  
☐

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9. How concerned are you that patients will be affected by stock shortages?

- a) Very concerned  
b) Some concern, but not overly worried  
c) Not at all worried

☐  
☐  
☐

10. Have you ever known a patient whose health has suffered because you were having difficulty sourcing a branded drug?

- a) Yes – please provide details

☐

- b) No

☐

Fill in the survey online

Completing the survey just got even easier thanks to the C+D website. You can return the form to us electronically instead by completing the questions at [www.chemistanddruggist.co.uk](http://www.chemistanddruggist.co.uk)

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Pharmacy name and address: \_\_\_\_\_

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Post this completed page to: Stock Survey, C+D, Riverbank House, Angel Lane, Tonbridge, Kent TN9 1SE or fax it to 01732 367065. All complete entries will be put into a draw for the iPod Shuffle

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# Script writing

Becoming a pharmacist prescriber requires legwork, but **Zoe Smeaton** finds the rewards are worth the effort

**D**evoting time to studying after you've achieved your pharmacy degree and have been enjoying the buzz of working with patients might not seem the most attractive option. But delve deeper and there is more to becoming a pharmacist prescriber than meets the eye. Although you will have to complete an accredited course (see panel, right), there are other equally important steps, and the benefits will soon make the effort worthwhile.

Alastair Buxton, head of NHS services at PSNC, says it's important that anyone thinking of becoming a prescriber works out how they want to use their skills afterwards, rather than seeing the qualification as a means to an end. You could think about prescribing for minor ailments, for example, or specialising in a particular clinical area.

At the C+D Awards 2009, shortlisted candidates for the Pharmacist Prescriber of the Year award ran everything from COPD and hypertension clinics to substance misuse services. Picking such a specialist area has career benefits as it will improve your clinical knowledge as you gain more experience. Eventually, you could consider using these skills to help you become a qualified pharmacist with a special interest (PhwSI).

Dan Guidi of DP Guidi Pharmacy in Glasgow, uses his prescribing qualification to support his smoking cessation service by prescribing varenicline. Offering such a complete service can bring great job satisfaction as it involves assessing patients, managing their conditions and also responding to their clinical problems. As Jane Lumb, training manager at Numark, says, becoming an independent prescriber can "open



Studying to become a pharmacist prescriber can bring long-term career benefits

up many doors for pharmacists to access new services and really put into practice their clinical skills".

It's not just job satisfaction, though. Developing your clinical skills will also show you're a pharmacist in tune with the move from a purely dispensing role to services delivery, which could make you more attractive to employers. In offering the services you'll be building rapport with patients, which is also an attractive trait to pharmacy businesses. Mr Guidi agrees that as an employer he would see a prescribing qualification as "a feather in someone's cap".

Through offering a new service you might also get the opportunity to work in different environments such as a specialist clinic for substance misuse, or homeless centres. This means you can demonstrate your ability to adapt and work under different conditions.

Whatever you choose to do with your qualification, though, will need to be agreed with your PCT, or whoever is going to fund the health service you are offering. Ms Lumb says this can often be the hardest part about becoming a prescriber. "You will need to get support locally and for this you really need to look at where you can add value to

patients and existing services," she advises. "Talk to your GPs to find out what they think and where they feel they could benefit from your new skills. Involving them at the beginning is the best way to make sure they work with you in the longer term."

Working with other healthcare professionals is a key skill for any pharmacist, so this experience is sure to help your career. Nina Barnett works as a prescribing pharmacist at a nursing home and says one of the most important things is her collaboration with other clinicians.

There are many benefits to becoming a pharmacist prescriber and it's worth getting started now as it is likely to become increasingly useful. Jonathan Mason, the DH's community pharmacy tsar, says as pharmacy becomes more clinically focused he expects to see a growth in the number of prescribers. He can see independent prescribing being used instead of measures such as patient group directions in the future, meaning you could be at the cutting edge of service innovations.

And if you're having doubts, just ask those who are already doing it. As Mr Guidi concludes: "There's no reason why any pharmacist can't do this... I would urge anybody to do it."

## Pharmacist prescribing: the basics

Pharmacists can train to become either independent prescribers, who can prescribe for any clinical area but only within their professional and clinical competencies, or supplementary prescribers, who monitor patients and prescribe further supplies of medicines after a diagnosis has been made and treatment initiated by another prescriber.

To qualify as either you must complete a training course accredited by the RPSGB.

Independent prescribing courses last 26 days, which may be spread over three to six months, and you must also complete 12 days of 'learning in practice' where you will be supervised by a medical practitioner.

To do the course you will need to develop a partnership with such a practitioner, as well as gain funding through local Workforce Development Confederations and obtain the agreement of the local health authority.

Supplementary prescribers who qualified less than five years ago can become independent prescribers by completing a conversion course, which lasts two days, plus two days learning in practice.

Once you obtain your prescribing qualification you will need to apply to have your entry on the RPSGB register annotated. Applications for annotation must be received by the RPSGB within six months of the date of the practice certificate. There is a fee of £49.

You will need to ensure your indemnity arrangements will cover your prescribing, and there is a whole set of professional standards and a clinical governance framework produced by the RPSGB for prescribers to adhere to.

### Further information

**For a list of accredited courses:**

[www.rpsgb.org.uk/registrationsandsupport/postgraduatecourses](http://www.rpsgb.org.uk/registrationsandsupport/postgraduatecourses)

**For more on both supplementary and independent prescribing:**

[www.rpsgb.org/worldofpharmacy/currentdevelopmentsinpharmacy/pharmacistprescribing/index.html](http://www.rpsgb.org/worldofpharmacy/currentdevelopmentsinpharmacy/pharmacistprescribing/index.html)

### Career tip of the week

"Analyse your needs and wants. Why are you looking for a new job? This is the key question to ask yourself. You will be asked this at every interview you attend so get it out of the way. Whatever your reason for looking, it is important to clarify your thought processes in a manner that you can convey to a future employer."

Adapted from Brilliant job hunting, by Angela Fagan

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# Postscript...

Mike Hewitson's diary of a new pharmacy owner

## Moisturiser mishap

"Can I return this?" asked my customer, somewhere in her mid-80s, placing a paper bag on the counter.

"What seems to be the problem?" I asked innocently, my hand reaching into the dark recesses of the bag. It was only when I had removed the item that I started to get nervous: a packet of Sylk vaginal moisturiser. I knew that once again I had engaged brain before mouth with potentially disastrous effect.

"I bought this last week – I thought it was sunscreen," my customer replied. "I was just about to put it on my nose, then I realised what it was."

It was all I could do to stop bursting into laughter, but thankfully professionalism prevailed. My poor customer, bless her, just kept repeating: "I don't do that any more." Fortunately, a bottle of factor 50 later and I think she left happy!

The rest of my week seems to have been

swallowed up by flu. For the last fortnight, in preparation for the autumn, I have been trying to write a pandemic contingency plan. The deeper I get into it the more things I realise need to be considered, which is a pain when your time is strictly limited.

I've been trying to get both of our local practices in a room to see how we can help each other, which is no mean feat when you consider the dispensing practice element, but I remain hopeful that we can all work together.

“IT WAS ONLY WHEN I HAD REMOVED THE ITEM THAT I STARTED TO GET NERVOUS: A PACKET OF SYLK VAGINAL MOISTURISER”



### Raiders of the lost archives

C+D 1859-2009

Celebrating 150 years in pharmacy

150

Death by lip balm. It might sound like an episode of Poirot or House, but this was the true tale of Miss Meredith, as reported in C+D's April 1860 Notions and Chips section.

Miss Meredith, of the wonderfully named Mogtree Limekiln, died "in the greatest agony, from the effects of applying some tallow to her lip, which had become chapped by the wind".

According to C+D, the balm contained "some poisonous matter or fat that had been much decomposed", resulting in Miss Meredith's tragic end.

Fortunately, the Notions and Chips section wasn't all doom and gloom. "An enterprising physician from Warrington," reported C+D, "has originated a new system of accommodation for pedestrians, in the shape of stone seats placed at intervals along the highways."

Go to a bench, then. At least future generations would have somewhere to sit down when playing Russian roulette with their lip balm.

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[www.chemistanddruggist.co.uk/birthday](http://www.chemistanddruggist.co.uk/birthday)

## Tufnell rises to the challenge



Cricket's Ashes series kicked off once again last week, but while the Aussies and Poms are tussling over a small beige pot full of charcoal, a new health campaign has launched to help raise impotence awareness.

The groan-inducing Bowl Your Maiden Over campaign (get it?) hopes to raise awareness of impotence treatments in men over 40. Fronted by former England bowler and I'm a Celebrity star Phil Tufnell (pictured), the campaign hopes to encourage men to, as King of the Jungle Phil puts it, "get down to your GP and make sure your kit is in order".

Postscript can't help but think of other bad cricket euphemisms. Sticky wickets, playing with balls and gripping your cricket bat all spring to mind. In fact, cricket seems to have

a lot of euphemisms tucked away: you wouldn't want the windies or runs either. To find out more about the campaign, go to [www.bowlyourmaidenover.com](http://www.bowlyourmaidenover.com).

## 150 C+D gets a ticking off

Postscript was chastened to receive the following letter this week from GRM Chisman, of Cornwall.

"I wish to point out an error in your publication (C+D, July 11, p4). In 'The answer is... 1859' box, you mention that Big Ben ticked for the first time in 1859. I say: impossible!

"Although everyone thinks of 'Big Ben' as the clock, or even the tower, the truth is Big Ben is the nickname for the Great Bell – which struck for the first time on July 11,

1859. The clock is Great Westminster Clock, and the tower is St Stephen's Tower. So, Big Ben can only be struck!

"My father was a horologist, and instilled this fact into me as a small child – every time the clock was referred to as Big Ben, he would become agitated at the ignorance of the newspaper or television reporter!"

It's good to know C+D readers are so well informed. If you have any suggestions for 'The answer is... 1859', please get in touch at [postscript@cmpmedica.com](mailto:postscript@cmpmedica.com)

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